Recovery Support:

Collaborating With Other Professions, Professionals, and Communities

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As these times are changing in the ever growing and expanding health care picture on a national level, the treatment of those with addictions clearly comes into focus and becomes a critical factor that cannot be overlooked. With the implementation of the Affordable Health Care Act and the expansion of Medicaid services within most states, those not only eligible for health care services but the subset of those with addictions will increase dramatically.

With a workforce already stretched and in dire shortage nationally, the injection of additional individuals perhaps previously not eligible for treatment will now have access and a method of reimbursement for those services available. The addiction treatment profession is making strides towards addressing this critical mass issue, however, it will be years before effective methodologies are in place to enhance the addiction treatment workforce, as well as augment it to a status even greater than it currently is.

To this end, new and creative methods of effectively addressing the treatment needs and looking at strategies and interventions that can assist the current treatment professionals, and, at the same time, augment and enhance treatment methodologies is already occurring. In fact, these interventions and disciplines have been in place in many parts of the country for years, but because of the increased demand and the evidence of it as an effective method of practice, it is becoming not only more popular, but seen as an adjunct to current levels of care being used in many treatment communities across the United States.

Addiction treatment has developed dramatically over the past 40 plus years and has become more refined and inclusive in the overall physical treatment of an individual. Strategies for care now include a more comprehensive and inclusion method of care that is structured and overseen by multi-disciplinary teams of treatment individuals. The individualized needs, and therefore the more individualized care, of each person seeking help have emerged. This more broad-based level of care has not only enhanced the delivery of care to those addicted, but research supports that this engagement and subsequent oversight focused on total care of the individual has been successful in more long term and successful recovery.

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The addiction treatment professional is no longer isolated into a specialized care sector, but in many instances, merged with other health professionals focusing on a variety of aspects of care for the total well-being of the client. These other professionals might include mental health professionals, including a psychologist or psychiatrist, as upwards of 50–75 percent of all those with substance use disorders have co-occurring mental health disorders.[1] In addition to this, a physician or physician's assistant may be monitoring their physical care, diet and related health issues. Non-medical staff such as a care coordinator, attorney, or education/vocational specialist may also be attending to other facets of the individual's care. We can no longer treat individuals in silos but must look at a comprehensive system of care that addresses the many different areas of need for these individuals. Furthermore, more and more clients are either directly coming from the prison system, or they are currently involved in drug courts or some type of day report system within the criminal justice system. This alone has injected a totally new, and in some instances, overwhelmingly large number of individuals into the treatment system.

Working within these multi-disciplinary teams requires a unique need for open and honest communication of ongoing care in all aspects. Team members need to be aware of and agree to methods being employed and understand the interaction and impact each team member plays in the total delivery of care to the client. They need to have rapid and open access to each other, discuss problem areas such as relapse or potential for other interferences, and discuss with each other the impact that successful or not so successful interventions are having.

A visual representation of what potential components and facets of care involved in a multi-disciplinary team is best exhibited in NIDA's *Principles of Drug Addiction Treatment*. This brief publication clearly outlines the different roles of direct care as well as ancillary treat-ment services and the participants that could be involved with the client's care.

Modern addiction treatment came of age in the 1960s and 1970s as a community-based phenomenon. You began to see the representation of recovering individuals and their families on agency boards and advi-

sory committees, as well as the recruitment of staff from local communities of recovery. More and more vibrant recovery volunteer programs began to spring up and you started to see regular meetings between the treatment organization and the service communities of the local recovery support fellowships.

Currently there is a paradigm shift that is occurring between the addiction treatment professional and peer recovery specialists. To this end, there is more of a focus on what occurs both before and after primary care and the transition from the professionally directed treatment plan to client developed recovery plans. The greater the physical, psychological and cultural distance between the treatment organization and the client's natural environment, the greater the problem of transferring the learning that has occurred. Treatment organizations must resemble more and more the surrounding community and the post treatment environment. Furthermore, they must promote client access to both pro-social and pro-recovery activities that take place within these environments.

Recovering communities take different shapes and forms and they will all address multiple issues in recovery for the client. There are the spiritual, religious, and secular communities of recovery that include the ever rapidly growing online support communities which are increasing in both number as well as diversity across the United States. A more popular recovering community is the recovering schools, colleges and universities that are all an integral part of a specialized recovery environment addressing the needs of this special population of recovering individuals.

Currently, there are three essential treatment-related strategies to assist in enhancing supportive healing power of the community in the long term recovery process: 1) outreach, 2) inreach and 3) recovery community building. Let's take a look at these three strategies.

Outreach is the extension of professional addiction treatment services into the everyday life of the community at large, including supporting clients in their own natural environment. This occurs after the client has completed some form of primary care treatment. Generally addiction professionals, alumni from treatment, as well as volunteers, are involved as you extend core treatment and recovery support beyond the walls of the primary care. Activities that you would typically see taking place are: recovery-focused education programs, promotion of screening and brief intervention, conducting assertive street and institutional engagement as well as increasing home-based service delivery. This approach is true outreach to the client within their homes and other social and living environments.

The next strategy, **inreach,** is the inclusion of indigenous community resources within the professionally directed addiction treatment. The kind of strategies that are employed here can include engaging family as well as social network members and the development of alumni groups. Organizations are more proactive in increasing recovery community representation on treatment boards of directors and/or advisory committees. With more and more focus on peer recovery coaching, some professional treatment organizations are now contracting directly with specialized recovery specialists to work with clients once they are discharged from direct care treatment. At this time, there are many variations of how these recovery specialists are being employed. There are many instances where these individuals are integrated as part of the multi-disciplinary team within the treatment organization or contracted within the community at large. Either way, the inclusion of these recovery specialists creates a continuum of care that reaches out past the professional addiction treatment provider.

The final strategy, **recovery community building,** includes activities that nurture the development of cultural institutions in which persons that are recovering from addiction can find relationships that are supportive to recovery, reciprocal in nature, and promote long-term recovery. These are usually representing knowledge and skills that are not dominated by a particular clinical practice or discipline and where the community is seen as the client in that it draws upon the knowledge from public health, social movement and community development and other organizations supportive of recovery. The addicted individual is embraced by a community that both understands, supports, and encourages recovery, and creates an environment of support for this recovery.

When looking at the development of a system of care that rolls out into the community from the professional treatment organizations, there are several issues that need to be closely regarded. It is generally believed that there are three critical points in shaping a philosophy of linkage between organizations and/or professionals and recovery mutual aid groups and recovery community organizations. Let's look at each of these.

First, professional treatment can be viewed as an adjunct to recovery mutual aid groups rather than just seeing such groups as an adjunct to treatment. In the past, mutual aid groups have often been looked upon as secondary aid measures to be employed after professional treatment has either been exhausted, tried and been unsuccessful, or simply as an adjunct to care. Research has supported since the mid-1950s that mutual aid groups have been tremendously successful in aiding and augmenting professional care and that, in many cases, addicted individuals maintain much longer and protracted involvement and commitment to this process and group than they ever did in professional care. In many instances when asked, individuals will state that their current recovery status is based on their long-time commitment to a particular mutual aid group.

Questions to consider while reading this article

What percentage of all those with substance use disorders have co-occurring mental health disorders?

What is required when working within multi-disciplinary teams?

Which resource outlines the different roles of direct care as well as ancillary treatment services and the participants that could be involved with the clients' care?

When did modern addiction treatment come of age?

What is the definition of outreach?

What is the definition of inreach?

What is the definition of recovery community building?

What kinds of activities involve outreach, inreach, and recovery community building?

Can recovery mutual aid groups serve as an alternative to professional help?

Participation in what generates better long term recovery outcomes?

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A second point to be considered is that recovery mutual aid groups can serve as an alternative to professional help. As stated above, this process has proven to be successful even for those that have long finished being actively involved in professional help. In many instances, individuals will opt out of professional help, strictly become involved in some type of mutual aid group, and maintain themselves and an improved lifestyle through this involvement without any formal professional help. This cannot be overlooked as a successful method for these individuals despite attempt from the treatment organizations believing and adhering to the tenet that the combination of both is indeed more beneficial to the individual.

A final point to consider is that participation in professional treatment and recovery support groups generates better long term recovery outcomes as opposed to just involvement in either professional treatment or recovery support groups by themselves. The synergistic effect of both the professional treatment in conjunction with some form of mutual aid group enhances and augments an individual's chances of more long term recovery because of the combination and approach to care. Furthermore, the mutual aide groups are a combination of both short-term and long-term individuals who can bring a unique form of insight and understanding for the addicted client as they begin their road to recovery. In addition to this, the system of support that exist professionally can assist the client in greater insight and understanding of co-occurring problems and disorders that when addressed in a therapeutic setting further enhance their long term recovery.

We do know that a large number of individuals that are being discharged successfully from treatment never transition to recovery support groups in the weeks and months following their discharge. This lack of linkage to a community-based recovery support system plays a large part in the lack of long term success for these clients in recovery.

Rapid entry into involvement with a recovery support group and continued involvement in these increase the probability of long term recovery. Treatment organizations need to embrace this alliance, not feel threatened by their presence, and rather see them for the mutual aid and support that these individuals and groups can bring towards the establishment of long term recovery for the addicted individual.

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REFERENCES

[1]White, W. & Kurtz, E. (2006). *Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches.* Pittsburgh, PA: IRETA/NeATTC.

[1&2]White, W. & Kurtz, E. (2005). *The Varieties of Recovery Experience.* Chicago, IL: Great Lakes Addiction Technology Transfer Center.

[1]"Varieties of Recovery Experience: A Primer for Addiction Treatment Professionals and Recovery Advocates" by William White, MA, and Ernest Kurtz, PhD (2005).

[2]"Building Resiliency, Wellness and Recovery — A Unified Vision for the Prevention and Management of Substance Use Disorders, — A Shift from an Acute Care to a Sustained Care Recovery Management Model," edited (2006) by Michael Flaherty, PhD, Executive Director of The Institute for Research, Education and Training on Addictions.